Carolina ACCESS
Contractual Compliance Survey
Results and Analysis
2002

I. BACKGROUND

In March through May of 2002, the Program Operations Staff of the Managed Care Section conducted a Carolina ACCESS Primary Care Provider Contractual Compliance Survey. The purpose of the survey was twofold: To measure contractual compliance to submit with the Managed Care waiver renewal and to strengthen the program by identifying potential educational opportunities. A copy of the survey is attached.

II. METHODOLOGY

Out of a total population of 1647 CA providers, 396 were selected by a stratified random sample. 368 responded to the survey. This represents 22% of the enrolled CA providers.

The six regional Managed Care Consultants administered the survey. It was designed to measure compliance of eight requirements:

- Office hours
- After hours accessibility
- Hospital admitting privileges
- Standards of appointment availability
- Coordination of care
- Recipient disenrollment
- Reports
- WIC

For each requirement the consultant asked the provider an open-ended question. For example instead of asking whether the PCP has hospital admitting privileges, he was asked the name of the hospital(s) where he had privileges. Program Operation staff will follow-up with all providers that were out of compliance on any requirement.

III. DATA COLLECTION

Prior to the survey, providers were notified via Medicaid Bulletin articles the goals and expectations of the survey. In addition, the consultants called each provider to schedule a time to complete the survey. After establishing an appointment, the consultants administered the survey by telephone. This maximized the response rate and enabled direct provider/consultant interaction.

IV. RESULTS

- **OFFICE HOURS AVAILABLE TO SEE PATIENTS**

  The CA contract requires PCPs to have a provider available in the office to see patients a minimum of 30 hours per week. Providers were asked what hours their office is open to see patients and is a doctor available to see patients during these hours.

99% of the providers meet the 30 hour a week minimum

- **AFTER HOURS ACCESSABILITY**

  The CA contract requires PCPs provide prompt access to medical advise 24 hours per day and seven days per week. The after hours telephone number is listed on the enrollees' monthly Medicaid card. Prompt is defined as returning a call to the member within one hour

  Providers were asked their after hours telephone number, hours it is available, the message, and response time. They were also advised that a consultant would call the number after house to confirm the message and response time. The percentage that responded that they comply may go down when the consultants verify the message and response time.

97% of the providers meet the 24 hour coverage requirement

- **HOSPITAL ADMITTING PRIVELGES**

  The CA contract requires PCPs to establish and maintain hospital admitting privileges OR a have a formal written arrangement with another physician or group practice for management of inpatient hospital admissions of enrollees. The privilege must be age appropriate.

  PCPs were asked to name the hospital(s) where they have admitting privileges or the name of the physician or group with whom they have a written agreement on file. They were advised that a consultant would call the hospital to confirm their privileges. The percentage that responded that they have privileges may go down when the consultants verify privileges with the hospital.

99% of the providers had age appropriate admitting privileges

- **STANDARDS OF APPOINTMENT AVAILABILTY**

  The CA contract requires PCPs to make appointment available to their enrollees based on the following standards:

Emergency notification	Immediately upon presentation or
Urgent	Within 24 hours
Routine sick care	Within 3 days
Routine well care	Within 90 days, 15 days in case of pregnancy
Telephone medical advice	24 hours a day with one hour response time

Providers were asked when an enrollee contacts his office, when is an appointment offered for well screening (Health Check), adult routine well care, pregnant women, routine sick care, urgent care and emergency care. Non-applicable was also an allowable response. The results varied from 97% to 99% for applicable standards.

98% complied with the standards of appointment availability (when applicable)

- **PATIENT CARE COORDINATION**

  The CA contract requires PCPs to coordinate the care of their enrollees. They must authorize referrals to other providers for services they do not provide directly or for specialty care. The referral process was designed to make referrals as easy as possible for PCPs. Each office can develop their referral protocols. Referrals may be in writing or telephone.

99% of the providers referred enrollees for specialty care

- **RECIPIENT DISENROLLMENT**

  The CA contract requires PCPs to notify enrollees in writing when it becomes necessary to disenroll a recipient due to repeated non-compliance, medication abuse, or missed appointments.

97% of the providers notify enrollees in writing at disenrollment

When an enrollee is disenrolled the PCP must continue to either provide service or refer the CA enrollee to another provider until the recipients CA status is changed in the system by the county department of social services.

99% of the providers continued to coordinate care at disenrollment

- **REPORTS**

  The CA contract requires PCPs to review their quarterly utilization report and ER management report and report discrepancies to the Managed Care Section. The results indicated a need to work closely with providers on this requirement. The Quality Management section is currently working with the UR report to make it a more useful tool for providers.

74% of the providers used their reports properly

- **WIC PROGRAM**

  The CA contract requires PCPs to refer potentially eligible enrollees to the WIC (Women, Infants, and children) program. A copy of the WIC Exchange of Information form is included in the PCP Manual. The results indicated a need to work closely with providers on this requirement. However, contact with the health departments indicates women and children are receiving WIC benefits.

79% of the providers referred to WIC (when applicable)

V. DISCUSSION

The state is divided into six geographical regions. Each region is assigned a Managed Care Consultant to assist providers in all areas. The survey includes statewide and regional results.

The results of the survey and provider interaction will be used to help identify strengths and possible areas for improvement within the CA program. A report will be prepared for each consultant listing each provider in his or her region who failed to comply with any contractual requirement. The consultants will work with their providers on an individual basis to assure compliance as soon as possible. The Managed Care Section will identify overall strategies and policy to help providers meet their requirements. A Medicaid bulletin article will be published in September outlining and reiterating the contractual requirements.